

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

11380

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
Gateway Nursing Home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16 North Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Clara Ankeney

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 16, 1856 8. (c) If alive, give age

8. AGE: Years 88 Months 11 Days 15 If less than one day

9. Birthplace Clearspring, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Isaac Ankeney
 13. Birthplace Clearspring, Maryland
 14. Maiden name Ella J. Ditto
 15. Birthplace Clearspring, Maryland

16. Informant John Ankeney
 Address Hagerstown, Maryland

17. Burial Date thereof 11-24, -45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory ST. Paul Cemetery
 Location Western Pike, near Clearspring

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. 11-23 - 1945 Levy M. Faller
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 - 45 19... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 - 45 19... to Nov 21 - 45 19...
 and that I last saw him alive on Nov 21 - 45 19...

Immediate cause of death

Due to Chr. Myocarditis
 Due to Smoking
 Other conditions Chronic ischemic
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Meane of Injury

23. SIGNATURE W. D. Suter M. D. or other
 Address Hagerstown, Md. Date signed 11/23/45

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DEC 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 306

1. PLACE OF DEATH:

County... Harb.
 City or town... Smithsburg md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25th
 Hospital, institution, or street address where death occurred:
 -
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Harb.
 City or town... Smithsburg md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... none
 (If rural, give LOCATION)
 2.(a) If veteran, name war... none

3. (a) FULL NAME

Mrs. Henrietta Jane Beare

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife... -
 6.(c) If alive, give age... years
 7. Birth date 4-6-1877
 deceased (mo., day, yr.)

8. AGE: Years 68 Months - Days 12 If less than one day
 ... hrs. ... min.

9. Birthplace... Hagerstown md
 (Town, county, and state)

10. Usual occupation... Housekeeping

11. Industry or business... -

12. Name Fred. F. Feltz

13. Birthplace Smithsburg md

14. Maiden name Anna L. Feltz

15. Birthplace Hagerstown md

16. Informant Yvonne Miriam Legg

Address Smithsburg md

17. (Burial, cremation, or removal) Which? Burial Date the 11-22-1945
 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown md

18. Funeral director Alfred B. Hoover

Address Smithsburg md

19. Nov-1945 1945 Pres. H. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945 at 12:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11/15/45 19... to 11/18/45 19...
 and that I last saw him alive on 11/18/45 19...

Immediate cause of death... Coronary Occlusion

Due to... Coronary Occlusion

Due to... Coronary Occlusion

Other conditions... Coronary Occlusion

(Include pregnancy within 3 months of death)

Major findings of operations... Coronary Occlusion

Date of op... Coronary Occlusion

Autopsy results... Coronary Occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of... Coronary Occlusion

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. J. Ferguson M. D. or other

Address... W. J. Ferguson Date signed... 11/18/45

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NOV 27 1945
BUREAU V. K.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

CERTIFICATE OF DEATH

11382

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Near Lecheville and
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wash
City or town Near Lecheville and
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Mrs. Ethel Pearl Barker.

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife _____
6.(c) If alive, give age _____ years
7. Birth date 11-21-1882
deceased (mo., day, yr.)

8. AGE: Years 63 Months 9 Days 7 If less than one day _____ hrs. _____ min.

9. Birthplace Near Smithsburg and
(Town, county, and state)

10. Usual occupation Housekeeping

11. Industry or business _____

FATHER 12. Name Julius Kinsdale
13. Birthplace Near Smithsburg

MOTHER 14. Maiden name Mollie Orvick
15. Birthplace Near Smithsburg

16. Informant Lero Barker
Address Fairfield Pa.

17. Buried Date thereof 11-25-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg
Location Smithsburg and

18. Funeral director Lero B. Hoover
Address Smithsburg and

19. Nov. 20 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1938 to Nov 18 1945
and that I last saw him alive on November 3 1945

Immediate cause of death Parasitic Agitation

Due to _____

Due to _____

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations No operation

Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE La. B. Bowers

Address Hagerstown Md. Date signed 11/20/45

MARGIN RESERVED FOR BINDING

VS A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 23 1945

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93.1)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

1737 Virginia Ave.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1737 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

John / Henry Brewer

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 30 1860

8. AGE:

Years

Months

Days

If less than one day

85513

.....hrs.min.

9. Birthplace

Sylvan Fulton Co. Pa.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Retired

12. Name

Henry R. Brewer

13. Birthplace

Sylvan Pa.

14. Maiden name

Catherine yeakle

15. Birthplace

Sylvan Pa.

16. Informant

Mrs. Irene Fulton

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/16/45

(month) (day) (year)

Cemetery or crematory

Rehobath Meth. Cemetery

Location

near Hancock Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19

45

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945 19..... at 9.15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 21, 1945 19..... to Nov. 13, 1945 19.....and that I last saw him alive on November 12, 1945 19.....

Immediate cause of death

Chronic Myocarditis with
congestive failure

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

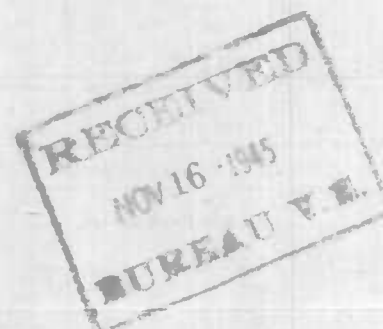
M. D. or other

Address 148 W. Washington St. Date signed Nov. 13/45

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11384

8

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
 City or town Sandy Hook, Md.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)
 Stay in this community (yrs., or mos., or days) 40 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Sandy Hook, Md. Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. R.R. #1
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Elva Madora Buffington

3. (b) Social Security Number

No

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Griffith Taylor Buffington

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 23 1859

8. AGE:

Years

Months

Days

If less than one day

86514

hrs.

min.

9. Birthplace

Lovettsville, Va.

(Town, county, and state)

10. Usual occupation

House Work

11. Industry or business

Home

FATHER

12. Name

Samuel Sanbower

13. Birthplace

Lovettsville, Va.

MOTHER

14. Maiden name

Anna Stoutsenburger

15. Birthplace

Lovettsville, Va.

16. Informant

Mrs Roy E. Johnson

Address

Knoxville, Md R.R. # 117. Burial

(Burial, cremation, or removal, Which?)

Date thereof Nov 9 1945

(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Sandy Hook, Md.

18. Funeral director

A. H. Backus

Address

Bolivar, W. Va.19. Nov 8

(Date rec'd by registrar)

19 45Cornelius A. Baxter

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 19 45 2:50A

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6 19 45 to Nov 7 19 45
 and that I last saw him alive on Nov 6 19 45

Immediate cause of death

Myocardial infarction

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

2 wks

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

 Address _____ M. D. or otherDate signed 11/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Dr. Ditto

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Broadfording
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 Years
 Hospital, institution, or street address where death occurred:
Hagerstown R.F.D. # 2
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Broadfording Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown R. F. D. #2
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Samuel Franklin Bussard

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 8.(b) Name of husband or wife Gertie
 8.(c) If alive, give age 79 years
 7. Birth date of deceased (mo., day, yr.) July 2 1866
 8. AGE: Years 79 Months 4 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Smithsburg Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Active

12. Name George Bussard
 13. Birthplace Smithsburg Md.

14. Maiden name Martha Beamer
 15. Birthplace Smithsburg Md.

16. Informant Mrs H. Basil Martin
 Address Hagerstown Md.

17. Burial Date thereof 11/27/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broadfording Cemetery
 Location Broadfording Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov. 27, 19 45 George H. Bussard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 45, at 8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1-45 19 45 to Nov 25-45 19 45
 and that I last saw him alive on Nov 24-45 19 45

Immediate cause of death _____ DURATION

Cerebral Lesion 6 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

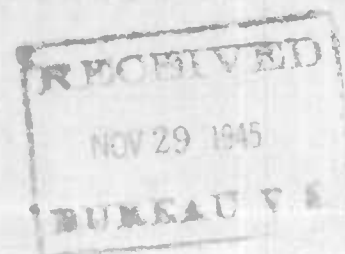
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. E. W. [Signature] M. D. or other

Address Hagerstown Md. Date signed 11/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Bell 11386

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Years
 Hospital, institution, or street address where death occurred:
101 Bellvieu Ave
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 101 Bellvieu Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Bernice Harriss Carper

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Chas. Edwin
 8. AGE: Years 77 Months 11 Days 13 If less than one day hrs. min.
 7. Birth date of deceased (mo., day, yr.) November 19 1867
 8.(c) If alive, give age - years

9. Birthplace Winchester Fred. co. X. VA.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name William Marker

13. Birthplace Shenandoah Va.

MOTHER 14. Maiden name Margaret Larriock

15. Birthplace Winchester Va.

16. Informant Miss Alda Carper

Address Hagerstown Md.

17. Burial Date thereof 11/3/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Hebron cemetery

Location Winchester Va.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 2 1945 Chas. H. Bower
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH November 1 1945 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 28, 1945 to Nov. 1, 1945
 and that I last saw him alive on October 27, 1945

Immediate cause of death Carcinoma of sigmoid DURATION 2

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ra. Bue M. D. or other

Address Hagerstown Md. Date signed 11/2/45

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NOV 5 1945

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 839

CERTIFICATE OF DEATH

Dr. Norment

Reg. Dist. No. 11382 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 years
 Hospital, institution, or street address where death occurred:
145 South Locust St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 145 South Locust St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Bessie May Clark

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.
 6.(b) Name of husband or wife Harry E.
 7. Birth date of deceased (mo., day, yr.) May 10 1881
 6.(c) If alive, give age 65 years
 8. AGE: Years 64 Months 6 Days 5 If less than one day hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Eavey Nunamaker

13. Birthplace Benevola Md.

14. Maiden name Mary E. Ridenour

15. Birthplace Myersville Md.

16. Informant Harry E. Clark

Address Hagerstown Md.

17. Burial Date thereof 11/18/45
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov-16-1945 Chas H. Povers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1945 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

DURATION

acute cerebral hemorrhage4 hrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells WASH. CO., MD.

Address Hagerstown Md. M. D. 11/16/45

Date signed 11/16/45

RECORDED

NOV 19 1945

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-1

CERTIFICATE OF DEATH

Reg. Dist. No. 11388 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alice Awilda Creager

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years
April 2 1865

8. AGE: Years Months Days If less than one day
80 7 27 hrs. min.

9. Birthplace Hancock
 (Town, county, and state)

10. Usual occupation Home work

11. Industry or business

12. Name William Creager13. Birthplace Hancock, Md.14. Maiden name Isabell Creager15. Birthplace Hancock Md16. Informant J. J. CreagerAddress Hancock, Md.

17. Burial Date thereof Dec. 1 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Episcopal CemeteryLocation Hancock, Md.18. Funeral director Snyder-RowlandAddress Hancock, Md.

19. Nov 30 1945 J. P. Keller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 19 45 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 38 to Nov 28 19 45
 and that I last saw her alive on Nov 28 19 45

Immediate cause of death myocarditis
 DURATION 2 1/2

Due to arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Keller
 M. D. or other

Address Hancock Md Date signed 11/29/45

RECEIVED
DEC 3 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11389 301

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport RFD #2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Pinesburg Williamsport RFD #2
(If outside city or town limits, write RURAL and give nearest town)Street No. Pinesburg Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William G. Crilly

3.(b) Social Security Number

#220-099-258

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MarriedB.(b) Name of husband or wife Emma Crilly6.(c) If alive, give age 50 years

7. Birth date of

deceased (mo., day, yr.) Sept. 22 1889

8. AGE:

Years

Months

Days

If less than one day

56113

hrs.

min.

9. Birthplace Clearspring Md.
(Town, county, and state)10. Usual occupation Tannery (Dope hides)11. Industry or business Tannery Williamsport, MdFATHER
MOTHER12. Name William Crilly13. Birthplace Ireland14. Maiden name Elizabeth Miller15. Birthplace Maryland16. Informant Emma CrillyAddress Williamsport, Md. RFD #217. Burial
(Burial, cremation, or removal. Which?)Date thereof Nov. 21 1945
(month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Williamsport, Maryland18. Funeral director Edith V LeafAddress #7 Church St. Williamsport, Md.19. Nov. 21 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19/45 1945 at 4:47 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/19/45 1945and that I last saw him alive on 11/19/45 1945

Immediate cause of death

Cerebral Occlusion

DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Williamsport, Md. Date signed 11/19/45

NOV 23 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

11390

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 weeks
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 12 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Death Curve Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Md. R. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Scott Dean

3. (b) Social Security Number

714-07-7031

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Annie E. Dean
 7. Birth date of deceased (mo., day, yr.) January - 2 - 1875 6.(c) If alive, give age _____ years
 8. AGE: Years 70 Months 10 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Allegheny Co. Md.
 (Town, county, and state)
 10. Usual occupation Retired Employee
 11. Industry or business American R. R. Express
 12. Name No Record
 13. Birthplace " "
 14. Maiden name No Record
 15. Birthplace " "

16. Informant Ralph Wilhite
 Address Hagerstown Md. R. 1
 17. Burial Date thereof Nov. 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Fairview Cemetery
 Location Kendysville Md.
 18. Funeral director Wm. J. Bast & Sons
 Address Brownsville Md.

19. Nov 16 1945 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1945 at 7:50 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1945 to Nov 14 1945
 and that I last saw him alive on Nov 14 1945
 Immediate cause of death Chronic Myocarditis
Chronic Nephritis
 DURATION 5 1/2 mos.
5 1/2 mos.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Isabel M. M. D. M. D. or other _____
 Address 1 Reservoir, Ind. Date signed 11/16/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 19 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

11391 302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington CountyCity or town Hagerstown Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

424 Salem Ave. Hagerstown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 Salem Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Edith De Laney

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Frank De Laney

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 1877

8. AGE: Years Months Days If less than one day

68916hrs.min.9. Birthplace Sharpsburg Md.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home

12. Name

13. Birthplace Sharpsburg Md.14. Maiden name Sarah Lopp15. Birthplace Sharpsburg Md.16. Informant Mrs. Frank De LaneyAddress 424 Salem Ave. Hagerstown, Md.17. Burial Date thereof Dec. 1 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Md.18. Funeral director Edith V LeafAddress #7 Church St. Williamsport, Md.19. Nov 30 19 45 Nov. 30 1945

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 19 45 at 6 7 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 1 19 45 to Nov 27 19 45and that I last saw her alive on Nov 27 19 45Immediate cause of death Cancer of sigmoidRectum

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Wm Allard BrownAddress Box W Wake Date signed 11-29-45

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
DEC 3 1945
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Dr. Wells

11392

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Years
Hospital, institution, or street address where death occurred:
73 West Side Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 73 West Side Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

William Herbert DeLauter

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Nora

8.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1878

8. AGE: Years 67 Months I Days 13 If less than one day hrs. min.

9. Birthplace Middletown Fredrick Co., Md.
(Town, county, and state)

10. Usual occupation Retired Invalid

11. Industry or business

12. Name George De Lauter

13. Birthplace Williamsport Md.

14. Maiden name No Record

15. Birthplace

16. Informant Mrs Nora De Lauter

Address Hagerstown, Md.

17. Burial Date thereof II/7/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Voffman

Address Hagerstown Md.

19. Nov-7 19 45 Chas. Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 19 45 at 12:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h. alive on 19

Immediate cause of death

DURATION

Acute coronary

obstruction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Wells M. D.

Address Hagerstown Md. Date signed Nov 6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 9 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto
11593

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 YearsHospital, institution, or street address where death occurred:
254 South Potomac St.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 254 South Potomac St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Mary Louise Brewer Draper

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow6.(b) Name of husband or wife J. Winger7. Birth date of deceased (mo., day, yr.) January 15 18658. AGE: Years Months Days If less than one day
80 10 1 hrs. min.9. Birthplace Welsh Run Franklin Col Pa.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Jacob Brewer13. Birthplace Germany14. Maiden name Katherine Brewer15. Birthplace Pittsburg Pa.16. Informant Mrs. Katherine DeBoltAddress Chicago Ill.17. Burial Date thereof 11/18/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov. 17. 45 Charles Brewer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1945 1945 at 12 Noon M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 44 to Nov 16 - 45 and that I last saw him alive on Mar 14 - 45 1945

Immediate cause of death

Ch. Myocarditis

DURATION

67

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

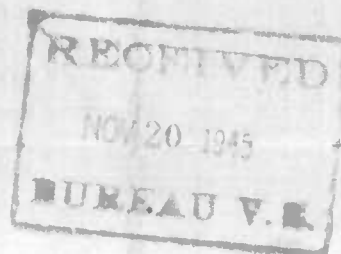
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE JW Ditto M. D. or otherAddress Hagerstown Md. Date signed 11/17/45

COPY SENT TO LOCAL REGISTRAR No. 302 DATE 11/19/45.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11394 303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
418 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 418 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charlotte Eichelberger

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Albert E. Eichelberger
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 30 1865
 8. AGE: Years 80 Months 6 Days 6 If less than one day
 hrs. min.

9. Birthplace Wayne Co. Ind.
 (Town, county, and state)
 10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Asa S. Selby
 13. Birthplace Not Known
 MOTHER 14. Maiden name Mary Everts
 15. Birthplace Not Known

16. Informant Miss Rae Eichelberger
 Address Hagerstown, Maryland

17. Burial Date thereof 11-7-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown, Maryland
 Location

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Nov 6 45 Charles H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5-45 19 45 at 2:10 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 20-45 19 45 to Nov 5 19 45
 and that I last saw her alive on Nov 5 19 45

Immediate cause of death Senility DURATION
 Due to arteriosclerosis
 Due to Ch. Myocarditis
 Other conditions Ch. Myocarditis
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Rae Eichelberger M. D. or other
 Address Hagerstown, Md. Date signed 11/6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 8 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 124 Blome Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
George Washington Evans

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 3/20/1880 6. (c) If alive, give age..... years

8. AGE: Years 65 Months 8 Days 6 If less than one day..... hrs. min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Preacher

11. Industry or business.....

12. Name George W. Evans, Sr.13. Birthplace Virginia14. Maiden name Mary L. Evans15. Birthplace Virginia16. Informant Mrs. Anna EvansAddress 124 Blome Ave.17. Burial Date thereof 11/29/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CemeteryLocation Rose Hill - Hagerstown, Md.18. Funeral director Wm. H. DowneyAddress 291 Frederick St.19. Nov 29 45 Blas H. Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov 19 45 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Nov 19 45 to 26 Nov 19 45 and that I last saw him alive on 25 Nov 19 45

Immediate cause of death Cerebral hemorrhage DURATION 3 days

Due to Hypertension ?

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE William D. Paymon, M.D.

Address 100 Professor St. Bldg. 28 Nov 45

Hagerstown, Md. Date signed.....

RECEIVED

DEC 1 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9370

CERTIFICATE OF DEATH

11395
302
Reg. Dist. No.

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
920 Hamilton Boulevard
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 920 Hamilton Boulevard
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alice K. Fahrney
3. (b) Social Security Number C

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Howard B. Fahrney
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) November 24, 1869
8. AGE: Years 75 Months 11 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Chambersburg, Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name Frank Rinehart
13. Birthplace Chambersburg, Pa.
MOTHER 14. Maiden name Larue Keefer
15. Birthplace Chambersburg, Pa.

16. Informant Daniel H. Fahrney
Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-45
(month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. Nov 21 1945 Cliff Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/45 19____ at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-23-45 to 11-19-45
and that I last saw h. alive on 11/17/45 19____

Immediate cause of death cerebral hemorrhage DURATION 4 days
Due to Hypertensive vascular disease } unknown
& generalized arteriosclerosis } many
Due to years
Other conditions None

(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Lo he W. Hornbaker M.D. M. D. or other
Address 154 W. Washington St. Date signed 11/19/45
Hagerstown

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED

NOV 23 1945

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 250

CERTIFICATE OF DEATH

1139702
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Bradens town
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington County Hospital
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pa County Franklin
City or town 134 W. Main St Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Waynesford Pa
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Ladonna Kay Hegel

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 27, 1944

8. AGE: Years 1 Months 3 Days 25 It less than one day _____ hrs. _____ min.

9. Birthplace Waynesford Pa
(City, county, and state)

10. Usual occupation Infant

11. Industry or business _____

FATHER 12. Name Eugene L. Hegel

13. Birthplace Waynesford Pa

MOTHER 14. Maiden name Blasfornia Sumner

15. Birthplace Washington D.C.

16. Informant E. L. Hegel

Address 134 W. Main St. Waynesford Pa

17. Burial Date thereof 11/25/45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Burma Hill Cemetery

Location Waynesford, Pa

18. Funeral director Walter J. Brown

Address 27 S. Church St. Waynesford Pa.

19. Nov. 22 19 45 Phasf. Rogers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 19 45, at 11:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 19 45, to Nov. 22 19 45, and that I last saw her alive on Nov. 22 19 45.

Immediate cause of death Tuberculous meningitis

DURATION

Due to Generalized Milinary Tuberculosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

01 operations _____

01 autopsy as above

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Phasf. Rogers M. D. or other _____

Address Phasf. Rogers Date signed 11/22/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged at statistically.

CERTIFICATE OF DEATH

RECEIVED
NOV 24 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

11398

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Clear Spring, Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Dry Run Dist.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Dry Run Dist.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Elizabeth A. Forsyth

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Isaac Forsyth

7. Birth date of deceased (mo., day, yr.) August 14, 1861 6.(c) If alive, give age..... years

8. AGE: Years 84 Months 3 Days 16 If less than one day
hrs.min.

9. Birthplace Falling Waters, W. Va.
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Joseph Barnes13. Birthplace ----- W. Va.14. Maiden name Maria Rohrer15. Birthplace ----- W. Va.16. Informant Isaac ForsythAddress Clear Spring, Md. R D17. Burial Date thereof Dec. 3, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's CemeteryLocation Clear Spring, Md. Rural18. Funeral director Snyder-Rowland Funeral HomeAddress Hancock, Md.19. Dec 3 19 45 Joseph W. Murray Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1945 19..... A..... M.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 44, to Nov 30, 19 45
 and that I last saw Nov 29, 19 45

Immediate cause of death.....

DURATION

Chronic Myocardial Sclerosis
 Due to..... 2 yrs.

Due to Arterio Sclerosis
 Other conditions Arterio Sclerosis 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or otherAddress Clear Spring Md. Date signed 12-3-45

RECEIVED
DEC 5 1945
BUREAU

RECEIVED
DEC 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Dr. Layman

57

11399

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. ---
(If rural, give LOCATION)2. (a) If veteran, name war ---

3. (a) FULL NAME

Miss Mary Ann Gordon

3. (b) Social Security Number

188-12-4615

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife ---6. (c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) July 28 19238. AGE: Years Months Days If less than one day
22 3 12 --- hrs. --- min.8. Birthplace Plum Run Fulton Co. Pa.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Douglas Garage12. Name Alvey B. Gordon13. Birthplace Plum Run Pa.14. Maiden name Valley Mouse15. Birthplace Elkins W. Va.16. Informant Homer WintersAddress Needmore Pa.17. Burial Date thereof 11/13/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Damascas CemeteryLocation Plum Run Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov. 11. 19 45 Shuffhower
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945 19 --- at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4 19 45, to Nov. 10 19 45and that I last saw her alive on Nov. 10 19 45

Immediate cause of death

DURATION

Cerebral edemaDue to Toxic jaundiceDue to ---Other conditions Diabetic mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ---

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

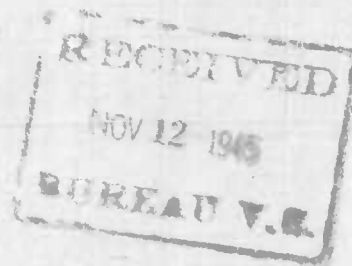
Accident, suicide, or homicide Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury Injured at work? ---23. SIGNATURE W. H. Layman, M.D.

M. D. or other

Address Hagerstown Md. Date signed 11/11-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1342

CERTIFICATE OF DEATH

11400

302

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Hotel Charles
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

John William Grandstaff4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife None6.(c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) November 2 18798. AGE: Years 66 Months 0 Days 4 If less than one day - hrs. - min.9. Birthplace Edinburg Shenandoah Co. Va.
(Town, county, and state)10. Usual occupation Fireman11. Industry or business Hotel Charles12. Name George Grandstaff13. Birthplace Edinburg Va.14. Maiden name Annie Shank15. Birthplace Edinburg Va.16. Informant Emmanuel G. GrandstaffAddress Hagerstown Md.17. Burial Burial Date thereof 11/8/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov 7 19 45 Chas H Boovers
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

214-09-5034

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1945 at 6 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 - - 19 45, to 11/6 - - 19 45and that last saw him alive on 11/5 - - 19 45Immediate cause of death Chronic Endocarditis" Nephritis "DURATION ?(?)Due to -Due to -Other conditions -

(Include pregnancy within 8 months of death)

Major findings of operations -Date of op. -Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ✓Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -Signature Victor Miller23. SIGNATURE Hagerstown Md. M. D. or other -Address Hagerstown Md. Date signed 11/7 19 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 9 1945
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 11491 366

1. PLACE OF DEATH:

County Washington

City or town Caretown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred Caretown Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash

City or town Caretown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Margaret E. Harrison

3. (b) Social Security Number

None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Charles Harrison

7. Birth date of deceased (mo., day, yr.) June 1862

6. (c) If alive, give age years

8. AGE: Years 83 Months Days If less than one day hrs. min.

9. Birthplace Wash Co. Md.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Edgar Harrison

Address Caretown Md.

17. Burial Date thereof Nov. 1945
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Beaver Creek

Location Beaver Creek

18. Funeral director W. J. Harris

Address Wagerstown Md

19. Nov 12 45 Registrar Geo. W. Ferguson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10-45 19 7 at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 19 45 and that I last saw her alive on Mar 19 19 46

Immediate cause of death Spasms and apoplexy DURATION 3 days

Due to Search engine of Sign. mod. Col. of 6 mos

Due to

Other conditions Apoplexy - 5 days 7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antemortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE E. G. N. Miller M. D. or other

Address San Antonio Date signed 11/1/45

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
NOV 14 1945
BUREAU V.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

★ Reg. Dist. No. 11402 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 22 years
 Hospital, institution, or street address where death occurred:
 Wash. Co. Hospital
 How long in hospital or institution?..... 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 232 East Franklin Street
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

George E. Huber

3. (b) Social Security Number

214-09-0640

4. Sex..... Male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Widower
 8. (b) Name of husband or wife..... Edith Huber
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 18, 1889
 8. AGE: Years..... 56 Months..... 3 Days..... 18 It less than one day..... hrs. min.

9. Birthplace..... Hummelstown, Pa.
 (Town, county, and state)
 10. Usual occupation..... Retired Cook
 11. Industry or business.....

12. Name..... George E. Huber
 13. Birthplace..... Hummelstown, Pa.
 14. Maiden name..... Mary E. Long
 15. Birthplace..... Hummelstown, Pa.

16. Informant..... Donald D. Huber
 Address..... Hagerstown, Maryland

17. Burial..... 11-8-45
 (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland

18. Funeral director..... C.M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Nov. 8 1945
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 5, 1945..... at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Feb. 12, 1945..... to 11/5/45.....
 and that I last saw him alive on November 5, 1945.....

Immediate cause of death.....
 Chronic myocarditis
 with congestive failure
 DURATION..... 1 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... same as above 11/6/45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

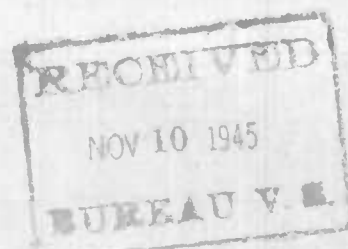
23. SIGNATURE..... M. D. or other

Address..... Hagerstown, Md. Date signed 11-7-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



George E. Huber

Father Jacob. Huber

Mother's Maiden name Mary E. Long.

Both born in

Hummelstown, Pa.

Chas. H. Bowers

Loc. Reg.

Dist. 302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

CERTIFICATE OF DEATH

★ 11443 302
Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 hoursHospital, institution, or street address where death occurred:
Hotel Alexander

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 211 So. Potomac St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Mary Herman Hunter

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife William H Hunter6.(c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) Sept. 11 18968. AGE: Years Months Days If less than one day
49 I 23 hrs. min.9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name H. Guy Herman13. Birthplace Middleburg Penna.14. Maiden name Eva S. Swartz15. Birthplace Hagerstown, Md.18. Informant William H. HunterAddress Hagerstown, Md.17. Burial Date thereof 11/5/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.19. Nov. 3, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 19 45 at 5 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19..... to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death..... DURATION

angina pectoris 1yrDue to.....
coronary sclerosis 1yrDue to.....
acute beginning pericarditisacute ventricular fibrillation

Other conditions.....

/fracture 5&6th rt. ribs Oct 31/45

(Include pregnancy within 8 months of death)

Due to Automobile accident

Major findings of operations.....

Antopsy results as above Date of op. Nov. 2/45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of October 31st. 1945Where did injury occur? near Martinsburg, West Virginia
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Automobile accident Injured at work?DEPUTY MEDICAL EXAM. S. Robert Wells23. SIGNATURE S. Robert Wells WASH. CO., MD.Address Hagerstown, Md. M. D. 11/3/45Date signed 11/3/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 6 1945

BUREAU V.E.

11/6/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Washington Registration Dist. No. 307
 Village or City Dargan, Md. No. 24 St. Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 2 yrs. 3 mos. 24 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Joyce Marie Ingram

If U. S. Veteran, specify WAR

(a) Residence: No. Dargan, Md. St. Ward.
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Single</u>		
6. DATE OF BIRTH (month, day, and year) <u>Aug 1 1943</u>		
7. AGE Years <u>2</u>	Months <u>3</u>	Days <u>23</u> If LESS than 1 day, <u> </u> hrs. or <u> </u> min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>None</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>None</u>	
	10. Date deceased last worked at this occupation (month and year) <u>No</u>	11. Total time (years) spent in this occupation <u>No</u>

12. BIRTHPLACE (city or town) Dargan, Md.
 (State or country)

FATHER 13. NAME Arnold James Ingram

14. BIRTHPLACE (city or town) Dargan, Md.
 (State or country)

MOTHER 15. MAIDEN NAME Lillie Mae Jemison

16. BIRTHPLACE (city or town) Dargan, Md.
 (State or country)

17. INFORMANT Mrs. Whylnenia Knight
 (Address) Harpers Ferry, W.Va. R.R.# 1

18. BURIAL, CREMATION, OR REMOVAL
 Place Samples Manor Md. Date Nov 25 1945

19. UNDEERTAKER J. H. Backus
 (Address) Bolivar, W.Va.

20. FILED Nov 25, 19 Corneilene M. Castle
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov 27, 1945
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov 24 1945 to Nov 27 1945
 I last saw him alive on Nov 23, 1945. Death is said to have occurred on the date stated above, at 2:50 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

3rd Degree Burn

Other Contributory Causes of Importance:

Asphyxia

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19
 Where did injury occur?
 (Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. H. Backus M. D.
 (Address) Harpers Ferry, W.Va.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diet. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Hours

Hospital, institution, or street address where death occurred:

Eyerlys Dept; StoreHow long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1164 Hamilton Blvd
(If rural, give LOCATION)2.(a) If veteran, name war First World War

3. (a) FULL NAME

Thomas A. Kratz

3. (b) Social Security Number

214-09-7513

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Frances S.6. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) Feby. 7 18978. AGE: Years Months Days If less than one day
48 9 7 hrs. min.9. Birthplace Clearspring Wash. Co. Md.
(Town, county, and state)10. Usual occupation Eyerlys Dept. Store11. Industry or business Manager-Furniture12. Name William H. Kratz13. Birthplace Martinsburg W. Va.14. Maiden name Anna Jane Mouse15. Birthplace Big Springs Md.16. Informant Mrs. Frances S. KratzAddress Hagerstown Md.17. Burial Date thereof 11/17/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov 16 19 45 Shackel

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 14 1945 19..... at 4.30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... DURATION

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.Hagerstown, Md. WASH. CO., MD.Address Hagerstown, Md. M. D. or otherDate signed 11/17/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 19 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

11406 No. 9

Reg. Dist. No. 3.05

1. PLACE OF DEATH:

County Washington
 City or town Mt. Kena Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Mt. Kena Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Earl S. Line

3. (b) Social Security Number

213-16-0562

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ester May Line
 7. Birth date of deceased (mo., day, yr.) May - 11 - 1910
 6. (c) If alive, give age _____ years
 8. AGE: Years 35 Months 6 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Breathedsale Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Cineman

11. Industry or business Potomac Edison Co.

12. Name John H. Line

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Nellie M. Snyder

15. Birthplace Hagerstown Wash. Co. Md.

16. Informant Mrs. Nellie M. Line

Address Kedzville Md. R. 1.

17. Burial Date thereof Nov 27, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm J. Bast & Sons

Address Boonsboro Md.

19. Nov 26 19 45 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov 25 - 45 19 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 - 45 19 Nov 25 - 45 19
 and that I last saw Nov 25 - 45 19 Nov 25 - 45 19

Immediate cause of death _____

Due to 4th deg burn of

Due to entire body

Other conditions _____

Major findings of operations _____

Antepoxy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

(Include pregnancy within 8 months of death)

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of 11/25/45

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? Boonsboro Md R 2 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Manner of injury Home burn Injured at work?

23. SIGNATURE Wm J. Bast M. D. or other _____

Address Boonsboro Md Date signed 11/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

Reg. Dist. No. 3.05

1. PLACE OF DEATH:

County Washington
 City or town Mt. Lena Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2.
 How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Mt. Lena Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Ester May Line

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Earl Line
 7. Birth date of deceased (mo., day, yr.) September - 6 - 1914
 6.(c) If alive, give age 25 years
 8. AGE: Years 31 Months 2 Days 19 hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Harry C. Hutzell

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Gertie Line

15. Birthplace Myersville Ind. Co. Md.

16. Informant Harry C. Hutzell

Address Boonsboro Md. R. 2

17. Burial Date thereof Nov. 27, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Chas. J. Bast & Sons

Address Boonsboro Md.

19. Nov. 26 19 45 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 - 45 19 45, at 7:15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 - 45 19 45, to Nov 25 - 45 19 45, and that I last saw him alive on Nov 25 - 45 19 45.

Immediate cause of death 4th deg burn of entire body
 Due to entire body
 Due to 20 min

Other conditions None
 (Include pregnancy within 3 months of death)

Major findings of operations None
 Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of 11/26/45
 Where did injury occur? Boonsboro Md. R. 2
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury Home Farm Injured at work?

23. SIGNATURE L. W. Seltz
 Address Hagerstown Md Date signed 11/26/45

RECEIVED
NOV 27 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30.2

1. PLACE OF DEATH:

County WITOM Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
731 Virginia Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 731 Virginia Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Ida B. Linebaugh

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Joseph Linebaugh

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

November 30, 1874

8. AGE: Years Months Days It less than one day

70 11 15 hrs. min.

9. Birthplace Graceham, Fred. Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name David Durbin
13. Birthplace Graceham, Maryland14. Maiden name Mary Engle
15. Birthplace Graceham, Maryland16. Informant Mrs. Ruth Snowberger
Address Hagerstown, Maryland17. Burial Date thereof 11-17-45
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland19. Nov. 17, 1945 Graceham, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1945 at 9:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 43 to Nov 14 1945
and that I last saw him alive on Nov 12-45 19

Immediate cause of death

Due to Chr. MyocarditisDue to Stroke

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or otherAddress [Signature] Date signed 11/16/45

RECEIVED

NOV 20 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 722

CERTIFICATE OF DEATH

Dr. Victor D. Miller 4/

11489

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 Years

Hospital, institution, or street address where death occurred:

829 Spruce St.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 829 Spruce St.
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Sarah Elizabeth Marlowe

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife LeviB. (c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) March 18 18658. AGE: Years 80 Months 7 Days 14 If less than one day hrs. min.9. Birthplace Front Royal Warren Co. Va.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name George Manuel13. Birthplace Front Royal Va.14. Maiden name Nancy Manuel15. Birthplace Front Royal Va.16. Informant Mrs. Otis BrewerAddress Hagerstown Md.17. Burial Date thereof 10/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Nov. 3 19 45 Blair Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 2 1945 19 45 at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1945 to 11/2 1945
and that I last saw him 11/1 alive on 11/1 19 45Immediate cause of death Chronic Endocarditis DURATION (?)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Victor D. Miller M. D. or other

131 W. WASHINGTON, ST.

Address HAGERSTOWN, MD. Date signed 11/3 1945

RECEIVED

NOV 6 1945

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> How long in above place of death?..... <u>9 days</u> Hospital, institution, or street address where death occurred: <u>Wash. Co. Hosp.</u> How long in hospital or institution?..... <u>9 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <small>(For newborn infants give residence of mother)</small> State..... <u>Penn.</u> County..... <u>Franklin</u> City or town..... <u>Lemasters</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> Street No..... <small>(If rural, give LOCATION)</small> 2(a) If veteran, name war..... <u>World War I</u>	
3. (a) FULL NAME <u>Howard B. McCullough</u>		3. (b) Social Security Number <u>none</u>	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Mary M. Cullough</u>			
7. Birth date of deceased (mo., day, yr.) <u>Apr. 28, 1897</u>			
8. AGE: Years Months Days If less than one day <u>48</u> <u>6</u> <u>19</u> hrs. min.			
9. Birthplace <u>Mercersburg, Pa. R.D.</u> <small>(Town, county, and state)</small>			
10. Usual occupation <u>Night Watchman</u>			
11. Industry or business <u>Penna. Highway Dept.</u>			
FATHER	12. Name <u>T.C. McCullough</u>		
	13. Birthplace <u>Ht. London, Pa.</u>		
MOTHER	14. Maiden name <u>Anna E. Brumbaugh</u>		
	15. Birthplace <u>Maryland</u>		
16. Informant <u>Mrs. Mary McCullough</u> Address <u>Lemasters, Pa.</u>			
17. Burial Date thereof <u>Nov. 20, 1945</u> <small>(Burial, cremation, or removal. Which?) (month) (day) (year)</small> Cemetery or crematory <u>Spring Grove Cem.</u> Location <u>Lemasters, Pa.</u>			
18. Funeral director <u>McIntyre & Sons</u> Address <u>Mercersburg, Pa.</u>			
19. Nov. 17, 1945 <small>(Date rec'd by registrar)</small> Registrar <u>Bessie H. Brown</u>			

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>Nov. 17, 1945</u> at <u>4:30 a.m.</u>	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov. 16, 1945</u> to <u>Nov. 17, 1945</u> and that I last saw him alive on <u>Nov. 17, 1945</u>	
Immediate cause of death <u>ULCER of Duodenum with MASSIVE Hemorrhage</u>	DURATION <u>2 weeks</u>
Due to	
Due to	
Other conditions <u>None</u>	
<small>(Include pregnancy within 3 months of death)</small>	
Major findings of operations <u>Ulcer of Duodenum</u> Date of op. <u>Nov. 16, 1945</u>	
Autopsy results <u>None done</u>	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide Date of	
Where did injury occur? <small>(City or town) (County) (State)</small>	
Injured at home, farm, industry, public place (where?)	
Means of Injury	Injured at work?
23. SIGNATURE <u>Richard J. Fowler</u> <u>Hagerstown, Md.</u> M. D. or other Address Date signed <u>Nov. 17, 1945</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

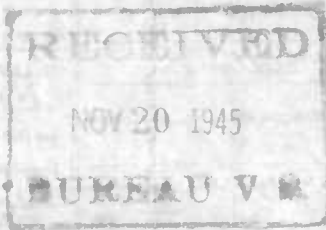
9. TIME OF DEATH

10. CAUSE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES



14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

26. SIGNATURE OF DECEASED

27. SIGNATURE OF DECEASED

28. SIGNATURE OF DECEASED

29. SIGNATURE OF DECEASED

29. SIGNATURE OF DECEASED

30. SIGNATURE OF DECEASED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Leitersburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Leitersburg, Md.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Leitersburg
(If outside city or town limits, write RURAL and give nearest town)Street No... Leitersburg
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Lewis S. McDowell

3.(b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife... Mary McDowell7. Birth date of deceased (mo., day, yr.) June 21, 1856 6.(c) If alive, give age... years8. AGE: Years 89 Months 5 Days 7 If less than one day
..... hrs. min.9. Birthplace... Wash. County, Md.
(Town, county, and state)10. Usual occupation... Blacksmith

11. Industry or business.....

12. Name... Samuel McDowell13. Birthplace... Wash. Co., Md.14. Maiden name... Elizabeth Kissinger15. Birthplace... Washington County, Md.16. Informant... Mrs. Frank EakleAddress... Leitersburg, Md.17. Burial Date thereof... Dec 1, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Lutheran CemeteryLocation... Leitersburg, Md.18. Funeral director... Fred W. KraissAddress... Hagerstown, Md.19. Dec 1 45 Phasff Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 28, 1945 10:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 19 40 to Nov-28 19 45
and that I last saw him alive on Nov-28 19 45Immediate cause of death... Ch. Vascular heart disease - double
Due to Generalized atherosclerosis - 2
Due to Arteriosclerosis
Other conditions.....

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE... Walter H. Bowers M.D.
M. D. or otherAddress... Waynesboro, Penna Date signed... 11/29/45

RECEIVED

DEC 4 1945

BUREAU

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302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

I. PLACE OF DEATH:
County..... Washington
City or town..... Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 months
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?..... 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 911 Forrest Drive
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME..... Mary Jane McMenamy
3. (b) Social Security Number.....

4. Sex..... Female
5. Color or race..... White
6. (a) Single, married, widowed, or divorced..... Widowed
6. (b) Name of husband or wife..... Hugh E. McMenamy
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... November 6, 1869

8. AGE:
Years..... 76 Months..... 0 Days..... 22
It less than one day..... hrs. min.

9. Birthplace..... Boonton, N.J.
(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business.....

FATHER
12. Name..... Barnard Riley
13. Birthplace..... Not Known

MOTHER
14. Maiden name..... Bridget Carey
15. Birthplace..... Not Known

16. Informant..... Mrs. George Scheck
Address..... Hagerstown, Maryland

17. Removal..... 11-29-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... St. Anthony Cemetery
Location..... Butler, N. J.

18. Funeral director..... C. M. Suter & Sons
Address..... Hagerstown, Maryland

19. Nov. 28. 1945
(Date rec'd by registrar) Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 28 1945, at..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 25 1945 to Nov 28 1945
and that I last saw him alive on Nov 27 1945

Immediate cause of death.....
Carcinoma of Breast
metastasis to vertebrae
liver
Due to.....

DURATION
0

Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... H. B. Porterfield M.D.
Address..... 136 W Washington St. M. D. or other
Date signed..... 11/28/45

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 30 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8353)

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
 City or town Rural--Trego, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Rural--Trego
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

George Clarence Miller

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Hattie--deceased

7. Birth date of deceased (mo., day, yr.)

Jan. 20, 1877

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

68

10

14

hrs.

min.

9. Birthplace Burkittsville-- Fred-- Maryland
(Town, county, and state)10. Usual occupation Retired rural mail carrier

11. Industry or business

FATHER

12. Name

Marshall Miller

13. Birthplace

Germany

MOTHER

14. Maiden name

Amanda Arnold

15. Birthplace

Burkittsville, Fred. Maryland

16. Informant

Clarence Miller

Address

Trego, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 5, 1945
(month) (day) (year)

Cemetery or crematory

Locust Grove

Location

Locust Grove, Maryland

18. Funeral director

R. I. Earnshaw

Address

Keedysville, Md.

19. Nov. 3 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945, at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 1945, to Nov 3 1945and that I last saw him alive on Nov. 2 1945

Immediate cause of death

DURATION

Cerebral Haemorrhage
Hypertension10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 11/3/45

RECEIVED

NOV 8 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 362

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 30 N. Mulberry St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Miller, James Wilson

3.(b) Social Security Number

217-10-2748

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Ida Kate Miller

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1873

8. AGE: Years Months Days If less than one day

72

6

6

hrs. min.

9. Birthplace Quincy, Franklin Co., Penna.
(Town, county, and state)10. Usual occupation Janitor11. Industry or business Employed by Frank S. Leiter12. Name John Miller13. Birthplace U.S.A. (Place unknown)14. Maiden name Lydia Amanda Jacobs15. Birthplace U.S.A. (Place unknown)16. Informant Mrs. Harvey HedquistAddress Norristown, Penna.17. Burial Date thereof Dec. 2, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director L. F. ReeherAddress Funkstown, Md.19. Dec 1, 45 Registrar Chas H Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 19 1945 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/23/45 to 11/30/45and that I last saw him alive on 11/29/45

Immediate cause of death

Cerebral hemorrhage DURATION 4 days

Due to

Due to

Other conditions

diffuse cerebral hemorrhage
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed 11/30/45

CERTIFICATE OF DEATH

RECEIVED

DEC 4 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-A

CERTIFICATE OF DEATH

Rd. B.B. Kneisley

11415

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Mos.

Hospital, institution, or street address where death occurred:

498 North Potomac St.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 498 No. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Katie Downey Miller

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife D. Frank6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.) July 23 1873

8. AGE:

Years

Months

Days

If less than one day

7242

hrs.

min.

9. Birthplace Downsville Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

George Downey

13. Birthplace

Williamsport Md.

MOTHER

14. Maiden name

Alice Highbarger

15. Birthplace

Williamsport Md.

16. Informant

Mrs. B. B. Kneisley

Address

Hagerstown Md.

17.

BurialDate thereof 11/28/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Manor Cemetery

Location

near Tilghmanton Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

Nov. 27, 1945

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 1945 at 11.45 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 2, 1945 1945 to Nov. 26 1945and that I last saw her alive on November 26, 1945 1945

Immediate cause of death

Chronic myocarditis with
congestive failure

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. Chronic myocarditis with signs of congestive failure.
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B.B. Kneisley M. D. or otherAddress 148 W. Washington St. Date signed 11/27/45

RECEIVED
NOV 29 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11415

304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Amanda B. Moore

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Hamilton Moore6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) September 13 18778. AGE: Years 68 Months 1 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Washington County
(Town, county, and state)10. Usual occupation Home Work

11. Industry or business

12. Name William Dancene13. Birthplace Pennsylvania14. Maiden name Ellen Younker15. Birthplace Pennsylvania16. Informant Hamilton MooreAddress Hancock17. Burial Date thereat Nov. 11 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory RehobethLocation Fulton Co. Pa.18. Funeral director Snyder-BowlandAddress Hancock, Md.19. _____ 19 _____
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945 19 _____ at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 36, to 11-8 19 45and that I last saw him alive on 11-8 19 45

Immediate cause of death _____ DURATION

RemanageCarcinoma of rectum

Due to _____

Carcinoma of rectum

Due to _____

HypertensionOther conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Herbert R. Thomas M.D.

M. D. or other _____

Address Hancock Md Date signed 11-10-45

RECEIVED
NOV 12 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 weeks
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Pittletown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Cora May Morgan

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Charles E. Morgan

7. Birth date of deceased (mo., day, yr.) January - 11 - 1879 6.(c) If alive, give age 66 years

8. AGE: Years 66 Months 9 Days 23 If less than one day hrs. min.

9. Birthplace near Myrtle Fred. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name William Sumner

13. Birthplace Myrtle Fred. Co. Md.

14. Maiden name Marjella Sumner

15. Birthplace Myrtle Fred. Co. Md.

16. Informant W. Whit Morgan

Address Boonsboro Md. R. 2

17. Burial: (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 7, 1945
 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Bart & Sons

Address Boonsboro Md.

19. Nov 5 45 Registrar Boonsboro

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 19 45 at 10:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 45 to Nov 4 19 45
 and that I last saw her alive on Nov. 3 19 45

Immediate cause of death Cancer of Descending Colon

Due to Cancer of Descending Colon

Due to Cancer of Descending Colon

Other conditions Cancer of Descending Colon

(Include pregnancy within 8 months of death)

Major findings of operations Cancer of Descending Colon

Date of op. Nov 4 1945

Autopsy results Cancer of Descending Colon

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Cancer of Descending Colon Date of Nov 4 1945

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Cancer of Descending Colon Injured at work?

23. SIGNATURE W. Whit Morgan M. D. or other

Address Boonsboro Date signed Nov 5, 45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. K. Van.



11417

47

RECEIVED

NOV 8 1945

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11418 302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>1110 Virginia Avenue</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1110 Virginia Avenue</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
3. (a) FULL NAME <u>Sallie A. Munday</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>Edgar J. Munday</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Feb. 21, 1882</u>				8. AGE: Years <u>63</u> Months <u>8</u> Days <u>25</u> If less than one day hrs. min.			
9. Birthplace <u>Clear Spring, Wash. Md.</u> (Town, county, and state) 10. Usual occupation <u>Home Duties</u> 11. Industry or business							
FATHER	12. Name <u>John Wilkes</u>						
	13. Birthplace <u>Wash. Co., Md.</u>						
MOTHER	14. Maiden name <u>Lissy Rockwell</u>						
	15. Birthplace <u>Big Spring, Md.</u>						
16. Informant <u>Edgar J. Munday</u> Address <u>1110 Va. Ave. - Hagerstown, Md.</u>							
17. Burial (Burial, cremation, or removal. Which?) Date thereof <u>Nov. 18, 1945</u> (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> Location <u>Hagerstown, Md.</u>							
18. Funeral director <u>Fred W. Kraiss</u> Address <u>Hagerstown, Md.</u>							
19. <u>Nov-18-45</u> (Date rec'd by registrar) <u>Phyllis H. Bowers</u> Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Nov. 15, 1945</u> 19..... at <u>4:30 P.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>June 20</u> 19 <u>45</u> , to <u>Nov 15</u> 19 <u>45</u> and that I last saw him alive on <u>Nov 15</u> 19 <u>45</u> Immediate cause of death <u>Primary Carcinoma Liver</u> DURATION <u>2</u> Due to Due to Other conditions (Include pregnancy within 8 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of Injury Injured at work? 23. SIGNATURE <u>H H Porterfield M.D.</u> M. D. or other Address <u>136 W Washington</u> Date signed <u>11/16/45</u>							

RECEIVED

NOV 21 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County WashingtonCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lottie C. Myers

3. (b) Social Security Number

217-18-8428

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John H. Myers6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) April 3, 18858. AGE: Years 60 Months 7 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Washington Co. Md.
(Town, county and state)10. Usual occupation House Wife11. Industry or business Own Home12. Name Unknown

13. Birthplace

14. Maiden name Lizzie Wissinger15. Birthplace Unknown16. Informant J.A. MyersAddress Smithsburg Md.17. Burial Date thereof Nov. 12, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Smithsburg CemeteryLocation Smithsburg Md.18. Funeral director Scott F. Minnich & SonAddress Hagerstown Md.19. Nov 11th 45
(Date rec'd by registrar)Geo. F. Ferguson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1945 3:40 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 1945 to Nov 9 1945
and that I last saw her alive on Nov 5 1945

Immediate cause of death

Carcinoma of Breast (right)

DURATION

2 years

Due to

Metastasis 18 mos.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter H. Hines, M.D.
M. D. or other W. Hines, Pa
Address _____ Date signed 11/10/45

RECEIVED
NOV 12 1965
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

11420
302

Reg. Dist. No.

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown,</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>4 Days</u> Hospital, institution, or street address where death occurred: <u>Washington Co. Hospital</u> How long in hospital or institution?..... <u>4 Days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown R.D. 4</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>None</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Mrs Louisa G. Myers</u>				3. (b) Social Security Number <u>None</u>			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>			
6. (b) Name of husband or wife <u>J. Rush</u>				6. (c) If alive, give age <u>65</u> years			
7. Birth date of deceased (mo., day, yr.) <u>Oct. 16, 1880</u>				8. AGE: Years..... <u>65</u> Months..... <u>0</u> Days..... <u>21</u> If less than one day..... hrs. min.			
9. Birthplace <u>Washington Co. Maryland</u> (Town, county, and state)				10. Usual occupation <u>House Wife</u>			
11. Industry or business <u>Own Home</u>				12. Name <u>Jacob Maishok</u>			
13. Birthplace <u>Germany</u>				14. Maiden name <u>Lydia Shhwinger</u>			
15. Birthplace <u>Germany</u>				16. Informant <u>J Rush Myers</u> Address..... <u>Hagerstown, R.d. 4</u>			
17. Burial (Burial, cremation, or removal. Which?) Date thereof..... <u>Nov. 11/45</u> (month) (day) (year) Cemetery or crematory..... <u>Dundard Cemetery</u> Location..... <u>Broadfording, Near Cearfoss, Md</u>				18. Funeral director <u>A.E. Minnick</u> Address..... <u>Greencastle, Penna.</u>			
19. (Date rec'd by registrar) <u>Nov. 9. 45</u>				20. (Date rec'd by registrar) <u>Bluff Boevers</u> Registrar			

MEDICAL CERTIFICATION	
20. DATE OF DEATH <u>Nov 7 - 45</u> at..... M	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Oct 1 - 45</u> 19..... to <u>Nov 7 - 45</u> 19..... and that I last saw..... alive on <u>Nov 7 - 45</u> 19..... Immediate cause of death..... <u>stroke following</u> <u>fracture of femur</u> Due to..... Due to..... Other conditions..... <u>arteriosclerosis</u> <u>hypertension</u> (Include pregnancy within 3 months of death) Major findings of operations..... Date of op. Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... <u>suicide</u> Date of..... <u>11/3/45</u> Where did injury occur?..... <u>Hagerstown, Md</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where)?..... <u>home</u> Means of injury..... <u>Self</u> Injured at work?..... <u>no</u>	23. SIGNATURE <u>Dr. Ditto</u> <u>Hagerstown, Md</u> M. D. or other..... Address..... Date signed..... <u>11/8/45</u>

RECEIVED

NOV 12 1945

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

Reg. Dist. No. 11121307

1. PLACE OF DEATH:
 County Washington
 City or town Williamsport R.F.D. #1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Williamsport R.F.D. #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Alexander Bradley Nave

3. (b) Social Security Number
213 24 7580

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

B. (b) Name of husband or wife Annie Teach

7. Birth date of deceased (mo., day, yr.) June 18 1872

8. AGE: Years 73 Months 3 Days 23 If less than one day _____ hrs. _____ min.

9. Birthplace Williamsport Md.
 (Town, county, and state)

10. Usual occupation Farm Hand

11. Industry or business Laborer

12. Name Joseph Nave

13. Birthplace Williamsport Md

14. Maiden name Martha Rouff

15. Birthplace Maryland

16. Informant Alex Jr Nave

Address Williamsport R.F.d. #1

17. Burial Date thereof Nov 13 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mennonite Cem

Location Clearspring Md

18. Funeral director Edith V. Leaf

Address Williamsport Md

19. Nov. 13 19 45 Mrs E L McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 19 45 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Amputation of both

Due to thighs through

pelvis region

Due to Hemorrhage & Shock

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov. 10/45

Where did injury occur? Pinesburg Wash. D.C.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Wash. D.C. R.R.

Means of injury Ran over by train Injured at work? no

23. SIGNATURE St Robert & Wells WASH. CO. 10, M. D. on 10/10/45

Address Hagerstown Md. Date signed Nov 10/45

DEPUTY MEDICAL EXAM.

RECEIVED
NOV 15 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
County.....
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 20 years
Hospital, institution, or street address where death occurred:
457 W. Washington Street
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Washington
City or town..... Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 457 W. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Mary Della Nicholson

3. (b) Social Security Number
212-24-5112

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife..... Edward J. Nicholson
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) March 8, 1893
8. AGE: Years 52 Months 7 Days 24 If less than one day..... hrs. min.

9. Birthplace..... Luray, Virginia
(Town, county, and state)
10. Usual occupation..... Home Duties
11. Industry or business
12. Name..... Andrew Smith
13. Birthplace..... Luray, Va.
14. Maiden name..... Beatta Summer
15. Birthplace..... Luray, Va.

16. Informant..... Mrs. John D. Smith
Address..... Leitersburg, Md.

17. Burial Date thereof Nov. 6 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rest Haven Cemetery
Location..... Hagerstown, Md.

18. Funeral director..... Fred W. Kraiss
Address..... Hagerstown, Md.

19. Nov-3 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 1, 1945 19 7:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 - 45 Nov 1 - 45
and that I last saw him alive on Oct 21 - 45 19

Immediate cause of death..... Cerebral Hemorrhage DURATION 3 hrs
Due to.....
Due to..... High blood pressure & arteriosclerosis 15 yrs
Other conditions.....
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... E. W. Smith M. D. or other
Address..... Date signed..... 11/4/45

RECEIVED

NOV 6 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 11423 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yearsHospital, institution, or street address where death occurred:
22 Bellevue Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 Bellevue Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Oliver Norris

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charity Ann Norris7. Birth date of deceased (mo., day, yr.) Feby. 7, 1871
8. (c) If alive, give age _____ years8. AGE: Years 74 Months 9 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Harford County, Md.
(Town, county, and state)10. Usual occupation Cabinet Maker11. Industry or business Retired12. Name John J. Norris13. Birthplace Harford County, Md.14. Maiden name Martha McComas15. Birthplace Harford County, Md.16. Informant Mrs. Rhoda A. GroganAddress 22 Bellevue Ave.- Hagerstown, Md.17. Burial Date thereof Nov. 20, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Nov 20 19 45 Charles H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1945 19 2:30 PA M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-43 19 Nov 18-45
and that I last saw him alive on Nov 1-45 19 _____

Immediate cause of death _____ DURATION _____

Due to Cerebral Hemorrhage 3 yrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work?

23. SIGNATURE SW Bowers M. D. or other _____Address Hagerstown Date signed 11/24/45

RECEIVED
NOV 23 1915
BUREAU P.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
211 East Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 211 East Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles B. Phillips

3. (b) Social Security Number

578-14-2294

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Married	
6.(b) Name of husband or wife <u>Nellie Phillips</u>			
6.(c) If alive, give age <u>61</u> years			
7. Birth date of deceased (mo., day, yr.) <u>March 21, 1886</u>			
8. AGE: Years <u>59</u>	Months <u>7</u>	Days <u>24</u>	If less than one day hrs. min.
9. Birthplace <u>Union Bridge, Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Auto Mechanic</u>			
11. Industry or business <u>Thumma Motor Company</u>			
FATHER	12. Name <u>Benj. F. Phillips</u>		
	13. Birthplace <u>Union Bridge, Maryland</u>		
MOTHER	14. Maiden name <u>Elizabeth Graham</u>		
	15. Birthplace <u>Union Bridge, Maryland</u>		

16. Informant <u>Mrs. Charles Phillips</u>	
Address <u>Hagerstown, Maryland</u>	
17. Burial	Date thereof <u>11-17-45</u>
(Burial, cremation, or removal. Which?)	(month) (day) (year)
Cemetery or crematory <u>Rose Hill Cemetery</u>	
Location <u>Hagerstown, Maryland</u>	
18. Funeral director <u>C. M. Suter & Sons</u>	
Address <u>Hagerstown, Maryland</u>	
19. <u>Nov 17, 1945</u>	Registrar <u>W. H. Howard</u>
(Date rec'd by registrar)	

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1945 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1945 to Nov. 13, 1945 and that I last saw him alive on November 13, 1945

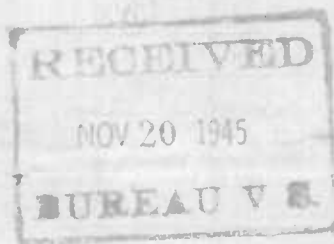
Immediate cause of death Carcinoma of esophagus DURATION About 6 mos.
 Due to
 Due to
 Other conditions None

(Include pregnancy within 8 months of death)
 Major findings of operations Carcinoma of esophagus Date of op.

Autopsy results No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Ra. Bee M. D. or other
 Address Hagerstown, Md. Date signed 11/17/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 4 East Antietam St.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War

3. (a) FULL NAME

Daly H. Poffenbeger

3. (b) Social Security Number

530-14-0023

4. Sex

Male

5. Color or race

White

6. (a) Single; married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September - 4 - 1868

8. AGE:

Years

Months

Days

If less than one day

77129

hrs.

min.

9. Birthplace New Rochersville Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

Rancher

11. Industry or business

12. Name William H. Poffenbeger13. Birthplace Rochersville Wash. Co. Md.14. Maiden name Marion Barnes15. Birthplace Mt. Airy Md.16. Informant Mrs. Katherine DagenhartAddress Rochersville Md.17. Burial Date thereof Nov. 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rochersville CemeteryLocation Rochersville Md.18. Funeral director Wm E. Bart & SonsAddress Boonsboro Md.19. Nov-5-1945 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3-45 19..... at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from

Sept 1-40 19..... to Nov 3 19.....and that I last saw him alive on Nov 3-40 19.....

Immediate cause of death

DURATION

Cerebral Hemorrhage

Due to

arterio-scleroticin ganglion of foot

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE [Signature] M. D. or otherAddress Hagerstown Md Date signed 11/7

MARGIN RESERVED FOR BINDING

VS A15

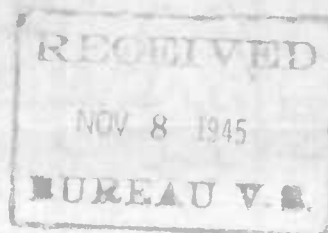
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Dale

I

11425

48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Diat. No. 11425 382

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R.R. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 3 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R.R. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mary Ann Provord

3.(b) Social Security Number

4. Sex 7 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 8.(b) Name of husband or wife Charles Provord
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 12, 1872
 8. AGE: Years 73 Months 4 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Kaiser
 13. Birthplace Washington Co. Md.
 MOTHER 14. Maiden name Mary Ellen Carl
 15. Birthplace Washington Co. Md.

18. Informant Miss Joe Kaiser
 Address Hagerstown R.R. 2

17. Buried Date thereof Nov. 4, 1945
 (Burial, cremation, or removal; Which?) (month) (day) (year)
 Cemetery or crematory Broadfording
 Location Md.

18. Funeral director John J. Hartz
 Address 1718 Church St. Hagerstown Pa.

19. Nov 3 19 45 Chas. B. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 19 45 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 19 45 to Oct 31 19 45
 and that I last saw her alive on Oct 31 19 45

Immediate cause of death _____

DURATION

Due to _____

Due to Cerebral thrombosis

Due to _____

Other conditions Hyperbittis Leuca

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John J. Hartz M.D.
 Address Hagerstown Md. Date signed 11-3-45

CERTIFICATE OF DEATH

RECEIVED

NOV 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

CERTIFICATE OF DEATH

Reg. Dist. No. 11427 306

1. PLACE OF DEATH:

County WashingtonCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WashingtonCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Annie May Ridenour

3. (b) Social Security Number

0

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced m.6. (b) Name of husband or wife Samuel I. Ridenour7. Birth date of deceased (mo., day, yr.) July 6, 18656. (c) If alive, give age 83 years8. AGE: Years 80 Months 3 Days 28 hrs. min.9. Birthplace Washington Co., md.
(Town, county, and state)10. Usual occupation House Duties

11. Industry or business

12. Name Jacob Stephy13. Birthplace Leitesburg md.14. Maiden name Catherine Rhine15. Birthplace Wolferville md.16. Informant Mr. Samuel RidenourAddress Smithsburg md.17. Burial, cremation, or removal, Which? Burial Date thereof Nov 7, 1945
(month) (day) (year)Cemetery or crematory Smithsburg C.

Location

18. Funeral director Walter H. GroveAddress 27 d Church St., Waynesboro Pa.19. Nov 6 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1945 at 1:38 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 4 1945and that I last saw him alive on Nov 4 1945Immediate cause of death Coronary Thrombosis DURATION 2 daysDue to Myocardial infarctionDue to Arteriosclerosis 1945Other conditions L

(Include pregnancy within 3 months of death)

Major findings of operations L

Date of op. _____

Autopsy results L

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. C. H. of Dr. M. D. or otherAddress Smithsburg Date signed 11/7/45

RECEIVED
NOV 12 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B5)

CERTIFICATE OF DEATH

11428
302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
623 Frederick Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 623 Frederick Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

T. Biser Ringer

3. (b) Social Security Number

218-241-1328

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Gertrude M. Ringer
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) October 25, 1880

8. AGE: Years 65 Months 0 Days 12 If less than one day hrs. min.

9. Birthplace Boonsboro, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Dyer & Cleaner

11. Industry or business Self

12. Name Thomas B. Ringer

13. Birthplace Near Tilghmanton, Md.

14. Maiden name Alice C. Derr

15. Birthplace Boonsboro, Md.

16. Informant Mrs. T. Biser Ringer

Address Hagerstown, Maryland

17. Burial Date thereof 11-8-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C.M. Suter & Sons

Address Hagerstown, Maryland

19. Nov 8 19 45 Charles Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1944 to Nov. 6, 1945 and that I last saw him alive on Nov. 5, 1945

Immediate cause of death Anginal Heart Failure
Chronic Myocarditis
Chronic Pulmonary Tuberculosis
Emphysema
Chronic Int. Nephritis

Due to 2 yrs. +

Due to 10 yrs.

Due to 2 yrs. +

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of X

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. Howard Dyce

Address Hagerstown, Md

Date signed Nov. 7, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 10 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town) 2 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
21 S. Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 21 S. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Henry Alfred Russel

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) March 21, 1893 6. (c) If alive, give age _____ years
 8. AGE: Years 52 Months 8 Days 6 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1945 12:15 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Nov 27 1945
 and that I last saw him alive on Nov 26 1945

Immediate cause of death Acute coronary occlusion
 Due to Coronary sclerosis
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

DURATION

Minutes

9. Birthplace Berkley Spgs. Morgan -W. Va.
 (Town, county, and state)
 10. Usual occupation Post Master
 11. Industry or business Retired
 12. Name Joseph Russel
 13. Birthplace Morgan County, W. Va.
 14. Maiden name Mary Widmyer
 15. Birthplace Morgan County, W. Va.
 16. Informant Miss Marybelle Hoffman
 Address Hancock, Md.

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

17. Burial Date thereof Nov. 30, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greenway Cemetery
Berkley Spgs. W. Va.
 Location
 18. Funeral director Snyder-Rowland Funeral Home
 Address Hancock, Md.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

19. Nov 28 1945 Chas H Bowers
 (Date rec'd by registrar) Registrar

23. SIGNATURE R. S. Stauffer, M.D. M. D. or other
 Address Hagerstown, Md Date signed Nov 27, 1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

NOV 30 1945
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 114305

1. PLACE OF DEATH:

County Washington
City or town Monroe - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Boonsboro Md. R.I.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Monroe - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R.I.
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

Mary Schlosser

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) March - 6 - 1898 6. (c) If alive, give age 35 years

8. AGE: Years 47 Months 7 Days 25 If less than one day hrs. min.

9. Birthplace Monroe Wash. Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business at home

12. Name E. Thomas Schlosser

13. Birthplace Monroe Wash. Co. Md.

14. Maiden name Bessie Murray

15. Birthplace Wash. Co. Md.

16. Informant Leonard Schlosser

Address Boonsboro Md. R.I.

17. Burial Date thereof Nov. 4, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Bast & Sons

Address Boonsboro Md.

19. Nov. 3 19 45 John E. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 - 1945 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 - 1945 to Nov. 1 - 1945 and that I last saw him alive on Nov. 1 - 1945

Immediate cause of death Coronary Thrombosis

Due to Arterial Hypertension

Due to Arterial Hypertension

Other conditions Arterial Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations Arterial Hypertension

Autopsy results Arterial Hypertension

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Arterial Hypertension Date of Nov. 1 - 1945

Where did injury occur? Boonsboro Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Boonsboro Md.

Means of Injury Arterial Hypertension Injured at work?

23. SIGNATURE John E. Bast M. D. or other Boonsboro Md.
Address Boonsboro Md. Date signed 11/3/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade

No 8

RECEIVED
NOV 5 1945
RILEY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11431

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1 day
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington
 City or town..... Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

James Preston
Unnamed child of (Semanich)

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

November 8, 1945

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John J. Semanich

13. Birthplace

New York City

MOTHER

14. Maiden name

Helen Polinsky

15. Birthplace

Evenburg, Pa.

16. Informant

John J. Semanich

Address

Hagerstown, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

11-10-45

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

16. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

Nov 10, 45

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-9-45

19.....

at

11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-8-45

19.....

to 11-9-45

19.....

and that I last saw alive on 11-9-45

19.....

Immediate cause of death

DURATION

Pneumonia (7 mo)24 hr

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

L. E. Suter

M. D. or other

Address.....

Date signed.....

11/9/45

RECEIVED
NOV 12 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

613 George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 613 George Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Isaac Evan Shanholtz

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Rebecca F. Shanholtz6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

March 29, 1886

8. AGE:

Years

Months

Days

If less than one day

59714

hrs.

min.

9. Birthplace

Great Capon, W. Va.

(Town, county, and state)

10. Usual occupation

Retired Foreman

11. Industry or business

City of Hagerstown

FATHER

12. Name

William Shanholtz

13. Birthplace

Great Capon, W. Va.

MOTHER

14. Maiden name

Elizabeth Henderson

15. Birthplace

Great Capon, W. Va.

16. Informant

Mrs. Isaac E. Shanholtz

Address

Hagerstown, Maryland

17.

Burial

Date thereof

11-15-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

Date rec'd by registrar

Nov. 15 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 12-45

19.

at

11 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

NOV 17 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 DaysHospital, institution, or street address where death occurred:
Layman Nursing HomeHow long to hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 2
(If outside city or town limits, write RURAL and give nearest town)Street No. Layman Nursing Home
(If rural, give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Lottie Cromer Shelleman

3. (b) Social Security Number

217-16-29714. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife Charles C.6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) May 30 18958. AGE: Years 50 Months 5 Days 8 If less than one day - hrs. - min.9. Birthplace Hanover Adams Co. Pa.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name Clayton Cromer13. Birthplace Hanover Pa.14. Maiden name Mary J. Erb15. Birthplace Hanover Pa.16. Informant Roger ShellemanAddress Hagerstown Md.17. Burial Date thereof 11/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Oxford CemeteryLocation New Oxford Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. 11-10-45 19 Nov 10 1945 Registrar

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945 at 3 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Nov 8 1945and that I last saw him alive on Nov 6 1945Immediate cause of death Central Nervous SystemLines (Paralytic type)

DURATION

?Due to -Due to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Linney Koverster MD.Address Hagerstown Md. M. D. or other -Date signed 11-9-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11434 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
421 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 421 West Washington Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Margaret B. D. Shoemaker

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

B.(b) Name of husband or wife Samuel G. Shoemaker7. Birth date of deceased (mo., day, yr.) September 17, 1889 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
56 2 3 hrs. min.9. Birthplace Waynesboro, Pa.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Super Diffenderfer
13. Birthplace Waynesboro, Pa.MOTHER 14. Maiden name Anna M. Shiffler
15. Birthplace Waynesboro, Pa.16. Informant Mrs. Harry BarnhartAddress Hagerstown, Maryland17. Burial Date thereof 11-23-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Nov 21 1945 East Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20/45 19 at 47 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/18/45 19 to 11/20/45 19
and that I last saw him alive on 11/20/45 19

Immediate cause of death

Coronary Occlusion

DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. H. Bowers M. D. or otherAddress Hagerstown, Md Date signed 11/20/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 23 1945
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

★ Reg. Dist. No. 11435 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
109 Ray Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Ray Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Victor B. Showe

3. (b) Social Security Number

214-09-8501

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Rosa V. Showe8. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) March 27, 1888

8. AGE: Years Months Days If less than one day
57 7 28 hrs. min.

9. Birthplace Fairplay, Wash. Co. Md.
 (Town, county, and state)
Retired Engineer

10. Usual occupation

11. Industry or business

12. Name Jacob Showe
 13. Birthplace Tilghmanton, Maryland

14. Maiden name Eveline Highbarger
 15. Birthplace Fairplay, Maryland

16. Informant Mrs. Victor B. ShoweAddress Hagerstown, Maryland

17. Burial Date thereof 11-27-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland

19. Nov 26 1945 Phas Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov 24 1945 at 145 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 24 1945 to Nov 24 1945

and that I last saw him alive on Nov 24 1945

Immediate cause of death

DURATION

Hemophylia - Left
Rupture of cranial vessel

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

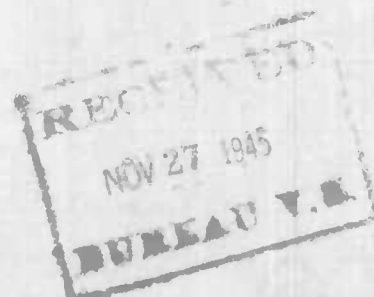
23. SIGNATURE Phas Bowers M. D. or other

Address Hagerstown Md Date signed 11/24/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

232 South Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington

City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 232 South Potomac Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David W. Smith

3. (b) Social Security Number

214-09-2191

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife..... Edna K. Smith6. (c) If alive, give age..... 49..... years

7. Birth date of

deceased (mo., day, yr.)

December 14, 1895

8. AGE:

Years

49

Months

11

Days

4

If less than one day

.....hrs.min.

9. Birthplace

Greenville, Tenn.

(Town, county, and state)

10. Usual occupation

Radiator Repairman

11. Industry or business

FATHER

12. Name..... Fred Smith13. Birthplace..... Greenville, Tenn.

MOTHER

14. Maiden name..... Ida.....15. Birthplace..... Greenville, Tenn.

16. Informant

Mrs. David W. Smith

Address

Hagerstown, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 11-21-45
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

Nov 21 19 45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 18, 1945 at 10 A.. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

DURATION

Gun shot wound through skull

Due to.....

hemorrhage & shock

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

no

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury.....

Revolver #32

Injured at work?

no

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. o

23. SIGNATURE.....

H. Robert & Wells

Address.....

Hagerstown, Md.

Date signed.....

11/17/45

RECEIVED
NOV 23 1945
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1340

CERTIFICATE OF DEATH



Reg. Dist. No.

11437

304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock Rural #1
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Milda Smith

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Cyrus Smith7. Birth date of deceased (mo., day, yr.) Oct. 15 1911

8. AGE: Years Months Days If less than one day

34 0 25 hrs. min.9. Birthplace Sylvan Pa.
(Town, county, and state)10. Usual occupation House Work

11. Industry or business

12. Name Barney Keefer13. Birthplace Fulton Co. Pa.14. Maiden name Ida Maller15. Birthplace Washington Co.16. Informant Cyrus SmithAddress Hancock, Md. R. #117. Burial Date thereof Nov. 13 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Little Cove Pa.18. Funeral director Snyder RowlandAddress Hancock, Md.19. _____ 19. _____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945 19. _____ 21. _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19. 40 to 11-9 19. 45and that I last saw h. her alive on 11-9 19. 45

Immediate cause of death

Cerebral HemorrhageDue to HypertensionDue to Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert R. Thomas M.D.Address Hancock, Md. M. D. or otherDate signed 11-10-45

RECEIVED

NOV 12 1945

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Mons.
 Hospital, institution, or street address where death occurred:
234 N. Potomac St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 234 N. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. None

3. (a) FULL NAME

Mary Frances Stanley

3. (b) Social Security Number

214-09-4837

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) Jan. 15 1893 6.(c) If alive, give age years

8. AGE: Years 52 Months 9 Days 19 If less than one day hrs. min.

9. Birthplace Shepherdstown, Jefferson Co. W. Va.
 (Town, county, and state)

10. Usual occupation Murphy Dry Cleaning11. Industry or business Seamstress12. Name Frank Stanley13. Birthplace Martinsburg W. Va.14. Maiden name Hester Callahan15. Birthplace Shepherdstown W. Va.16. Informant Laskie S. StanleyAddress Shepherdstown W. Va.

17. Burial Date thereof II/6/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ellwood CemeteryLocation Shepherdstown W. Va.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

19. Nov 5 45 Phyllis Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Nov. 4 19 45 at 1:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 45 to Nov 4 19 45 and that I last saw her alive on November 2 19 45

Immediate cause of death.....

DURATION

Carcinoma of cervix 2 1/2

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations No operation. Diagnosis confirmed by biopsy. Date of op.

Autopsy results if autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ra Bee M. D. or otherAddress Hagerstown Md. Date signed 11/5/45

RECEIVED

NOV 8 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 1143 3012

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

216 North Locust Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 North Locust Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

E. Howard Stouffer

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife Mary E. Stouffer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1864

8. AGE:

Years

81

Months

6

Days

14

If less than one day

hrs.

min.

9. Birthplace Funkstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business

FATHER

12. Name

C. W. Stouffer

13. Birthplace

Funkstown, Maryland

MOTHER

14. Maiden name

Anna Maria Miller

15. Birthplace

Funkstown, Maryland

16. Informant

Mrs. Helen J. Valentine

Address

Hagerstown, Maryland

17. Burial

Date thereof 11-23-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19.

(Date rec'd by registrar)

Nov 21 19 45 Phyllis Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 19 19 45 at 1230 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 45 to NOV 19 45

and that I last saw him alive on NOV 19 45

Immediate cause of death

Stroke in coming

DURATION

3

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

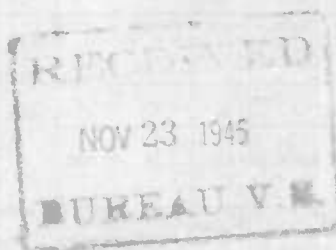
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 11440 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

148 Ray Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 148 Ray Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Melvina May Sweigert3. (b) Social Security Number
None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Preston E. Sweigert6. (c) If alive, give age 64 years

7. Birth date of

deceased (mo., day, yr.)

April 30, 1882

8. AGE:

Years 63Months 6Days 2

If less than one day

hrs.

min.

9. Birthplace Washington County, Md.
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

FATHER

12. Name Benjamin F. Myers13. Birthplace Franklin Co., Md.

MOTHER

14. Maiden name Rebecca Ann Daley15. Birthplace Franklin Co., Pa.16. Informant Preston E. SweigertAddress 148 Ray St.- Hagerstown, Md.17. Burial Date thereof Nov. 3, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Nov. 3 19 45 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1945 9:35 A. M. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 - 11/1 19 45 to 11/1 19 45 and that I last saw her alive on 10/20 19 45

Immediate cause of death

Chronic Sudo Carditis
Nephritis
Diabetes Mellitus

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ☒Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ☒

Means of injury Injured at work?

23. SIGNATURE V. H. Buehler M. D. or otherAddress 11/1 19 45 Date signed

RECEIVED

NOV 6 1945

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17006

CERTIFICATE OF DEATH

Reg. Dist. No. 1144-302

1. PLACE OF DEATH:

County Washington County

City or town Wagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sharpsburg Md.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Francis Allen Thomas

3.(b) Social Security Number

217-782849

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) March 9 1918 6.(c) If alive, give age years

8. AGE: Years 27 Months 8 Days 18 If less than one day X hrs. min.

9. Birthplace Sharpsburg Maryland
(Town, county, and state)

10. Usual occupation Merchant Marine

11. Industry or business Boat

12. Name Franklin H Thomas

13. Birthplace Sharpsburg Md

14. Maiden name Lucinda Mills

15. Birthplace Near Brownsville Md.

16. Informant Franklin H. Thomas (father)

Address Sharpsburg Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 30 1945
(month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Sharpsburg, Md.

18. Funeral director Edith V Leaf

Address #7 Church St. Williamsport, Md.

19. Nov 30 19 45 Charles H. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 19 45 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26, 1945 - 1 P.M. to Nov. 27 19 45 and that I last saw him alive on 19.....

Immediate cause of death Shock & Internal Hemorrhage DURATION 6 hours
Fracture of right 10th rib on left & hemorrhage
fracture of left 10th & 11th ribs
Automobile accident 11/26/45
Other conditions Lacerations of face and left knee
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results As stated

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11/26/45

Where did injury occur? Sharpsburg (City or town) Washington (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Auto accident Injured at work? No

23. SIGNATURE Walter H. Shady Jr

Address Sharpsburg Md M. D. or other

Date signed 11/28/45

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Dr. Ktitzer

11442

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 433 West Washington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. None

3. (a) FULL NAME

William Avery Tillett

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife.
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 13, 1945
 8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business

FATHER 12. Name William W. Tillett
 13. Birthplace Norfolk, Va.
 MOTHER 14. Maiden name Frances Somers
 15. Birthplace Luray Va.

16. Informant William W. Tillett
 Address Hagerstown Md.

17. Burial II/16/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Nov-16 19 45 Charles Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 19 45 at 2 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 - 19 45, to Nov 15 - 19 45,
 and that I last saw him alive on Nov 14 - 19 45

Immediate cause of death Premature Infant -
6 2 Nov -
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Charles Bowers M. D. or other
 Address Hagerstown Md. Date signed 11/16/45

REC-107.10

NOV 19 1945

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

11443

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

225 Winter Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 Winter St

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Wilford G. Unger

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Margaret E. Unger

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

March 27, 1854

8. AGE:

91 Years

Months

8

Days

3

If less than one day

hrs.

min.

9. Birthplace Loudon County, Va.

(Town, county, and state)

10. Usual occupation Retired Wood Worker

11. Industry or business

12. Name Frederick Unger

13. Birthplace Md.

14. Maiden name Elizabeth Diebert

15. Birthplace Md.

18. Informant Mrs. Alma Entler

Address Winter St. Hagerstown, Md.

17. Burial Date thereof Dec. 3, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Dec. 3 19 45 Phar. H. Bowers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1945 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 30 1945 to Nov 30 1945

and that I last saw him alive on Nov 30 1945

Immediate cause of death

Cerebral Apoplexy

DURATION

2 Days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE Ralph F. Gouge

Willie Ann Bowers M. D. or other

Address..... Date signed 12/1/45

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

DEC 6 1945

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 11444 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Regina Vance

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Hager Vance 8. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) May 3 1870
 8. AGE: Years 75 Months 6 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Hancock
 (Town, county, and state)
 10. Usual occupation Home Work
 11. Industry or business _____
 12. Name Thomas P. Gilliece
 13. Birthplace Ireland
 14. Maiden name Ann White
 15. Birthplace Ireland

16. Informant Hager Vance
 Address Hancock, Md.
 17. Burial Date thereof Nov. 7 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Peters Cemetery
 Location Hancock
 18. Funeral director Snyder-Rowland
 Address Hancock, Md.
 19. Nov. 6 1945
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH November 5 19 45, at 5.50 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/5 1945 to 11/5 1945
 and that I last saw him alive on 11/5 1945

Immediate cause of death Cerebral Hemorrhage DURATION _____
Arteriosclerosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Shaffer MDHancock Md M. D. or other _____Address _____ Date signed 11/6/45

Registrar

RECEIVED

NOV 8 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

Dr. Wells

CERTIFICATE OF DEATH

Reg. Dist. No.

302¹⁰ 306

1. PLACE OF DEATH:

County..... Washington
 City or town..... Beaver Creek
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 18 Years
 Hospital, institution, or street address where death occurred:
Hagerstown, R.D. 1
 How long in hospital or institution?..... none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown, R.D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Beaver Creek
 (If rural, give LOCATION)
NO
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Isaac Phillipy Vanderau

3.(b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife..... None
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... November 12, 1877
 8. AGE: Years..... 68 Months..... 0 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... New Franklin, Franklin Co. Pa.
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Adam Vanderau
 13. Birthplace..... Chambersburg, Pa.
 14. Maiden name..... Mary Phillipy
 15. Birthplace..... Greencastle Pa.

16. Informant..... Mrs Mary Shatzer
 Address..... Hagerstown, Md. R.D. 1

17. Burial Date thereof..... 11/23/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Cedar Hill cemetery
 Location..... Greencastle, Pa.

18. Funeral director..... Andrew K. Coffman
 Address..... Hagerstown, Maryland

19. Nov. 27 19 45 Geo. W. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 20, 1945 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 20 - 45 19 Nov 20 - 45
 and that I last saw him dead alive on Nov 20 - 45 19

Immediate cause of death.....

Coronary Disease
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (Country) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. E. W. Dittus acting
 Address..... Hagerstown, Md. M. D. or other

Date signed..... 11/24/45

RECEIVED
NOV 27 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

11446

Reg. Dist. No. 30/

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R # 3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Years
 Hospital, institution, or street address where death occurred:
Hopewell Road
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown R # 3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hopewell Road
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Sarah Elizabeth Wintermoyer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife John J.
 6.(c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) October 31 1885
 8. AGE: Years 60 Months 10 Days 12 If less than one day hrs. min.

9. Birthplace Hedgesville Berkeley Co. W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name J. Fredd Fuss

13. Birthplace Germany

14. Maiden name Mary M. Holmes

15. Birthplace Clearspring Md.

16. Informant John J. Wintermoyer

Address Hagerstown Md, R # 3

17. Burial Burial Date thereof 11/16/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hedgesville Cemetery

Location Hedgesville W. Va.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 14 1945 Mrs E Lee McClary
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945 19..... at 9.15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death..... DURATION

Chr. myocarditis 1yr

Due to acute ventricular fibrillation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations no

.....Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM.
Hagerstown, Md. WASH. CO., MD.
 M. D. or

Address Hagerstown, Md. Date signed Nov. 14/45

RECEIVED
NOV 19 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

Dr. Ditt 11447

★ Reg. Dist. No. 303

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown Md. R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 Days

Hospital, institution, or street address where death occurred:

Huyette's Cross Roads

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 W. Franklin ST.
(If rural, give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

Fredrick Charles Wisherd

3. (b) Social Security Number

062-09-9299

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife ElizabethB. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.)

May 23 1897

8. AGE:

Years

Months

Days

If less than one day

4862

hrs.

min.

9. Birthplace Beaver Creek Wash. Co., Md.
(Town, county, and state)10. Usual occupation Fairchild Aircraft11. Industry or business Protection Dept.

FATHER

12. Name

Charles Wisherd

13. Birthplace

Beaver Creek, Md.

MOTHER

14. Maiden name

Clara Kaylor

15. Birthplace

Beaver Creek, Md.

16. Informant

John M. Wisherd

Address

Hagerstown, Md.

17. Burial (Burial, cremation, or removal, Which?)

Date thereof

11/27/45

(month) (day) (year)

Cemetery or crematory

Fahrney Cemetery

Location

Near Mapleville Md.

18. Funeral director

Andrew K. Coffey

Address

Hagerstown, Md.

19.

11-27th
(Date rec'd by registrar)

19.

45
(Age at death)

19.

Joseph J. Zoch
(Signature of Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 45 at 3:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 10-45 19 45 to Nov 25-45 19 45and that I last saw him alive on Nov 24-45 19 45

Immediate cause of death

DURATION

Malignant Hypertension 2 yrs

Due to

Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. W. Ditt M. D. or otherAddress Hagerstown, Md. Date signed 11/27/45

RECEIVED

DEC 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
 How long in hospital or institution? 2 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Charfoss - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Md. R. 2
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Luther E. Wolfe

3. (b) Social Security Number

219-12-1385

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mildred Wolfe
 6. (c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) May-6-1921
 8. AGE: Years 24 Months 5 Days 27 If less than one day hrs. min.

9. Birthplace Boonsboro Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Manbeck Baking Co.

12. Name Frank Wolfe

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Estie Smith

15. Birthplace Beaver Creek Wash. Co. Md.

16. Informant Mrs. Mildred Wolfe

Address Hagerstown Md. R. 2

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov. 7, 1945
 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

16. Funeral director Wm. J. Bast & Sons

Address Boonsboro Md.

19. Nov-5-1945 (Date rec'd by registrar) Registrar Phyllis Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1945 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3, 1945 to Nov 3, 1945
 and that I last saw him alive on Nov 3, 1945

Immediate cause of death Intracerebral hemorrhage - left hemisphere

Due to Cause undetermined

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results as above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of Oct 27, 1945

Where did injury occur? Hagerstown (County) Md. (State)

Injured at home, farm, industry, public place (where)? Industry - truck driver

Means of injury Struck by truck Injured at work? yes

23. SIGNATURE P. J. Stauffer - Md. M. D. & other

Address Hagerstown, Md. Date signed Nov 5, 1945

RECEIVED

NOV 8 1945

BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

CERTIFICATE OF DEATH

11449502
Reg. Dist. No.

1. PLACE OF DEATH: Washington
 County: Hagerstown, Maryland
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution? 14 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Washington
 City or town: Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 500 Highland Way
 (If rural, give LOCATION)
 2.(a) If veteran, name war:

3. (a) FULL NAME

Goldie G. Yingling

3. (b) Social Security Number

4. Sex: Female
 5. Color or race: White
 6.(a) Single, married, widowed, or divorced: Married
 6.(b) Name of husband or wife: Harry L. Yingling
 6.(c) If alive, give age: 70 years
 7. Birth date of deceased (mo., day, yr.): April 25, 1876
 8. AGE: Years: 69 Months: 7 Days: 4 If less than one day: hrs. min.

9. Birthplace: Cavetown, Wash. Co., Md.
 (Town, county, and state)
 10. Usual occupation: Housewife
 11. Industry or business:

FATHER
 12. Name: Daniel H. Garver
 13. Birthplace: Leitersburg, Maryland
 MOTHER
 14. Maiden name: Jenny Beard
 15. Birthplace: Cavetown, Maryland

16. Informant: Maxwell Yingling
 Address: Hagerstown, Maryland

17. Burial: 12-1-45
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory: Rest Haven Cemetery
 Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
 Address: Hagerstown, Maryland

19. Nov. 30, 1945
 (Date rec'd by registrar) Registrar: [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29, 1945 at 2:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28, 1945 to Nov. 29, 1945
 and that I last saw her alive on Nov. 29, 1945

Immediate cause of death: Cerebral hemorrhage
 Due to: Arteriosclerosis
 Other conditions: 14 hrs
 2 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations: No
 Date of op.:
 Autopsy results: No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: X X X
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?):
 Means of injury: Injured at work?

23. SIGNATURE: W. Howard Yeager
 Address: Hagerstown, Md.
 Date signed: Nov. 30, 1945
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED
DEC 3, 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

I. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Route 40 West Clear Spring, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County _____City or town Rural Somerset R D 1
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war _____

3. (a) FULL NAME

Bernice J. Zerfoss

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
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6. (b) Name of husband or wife _____6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) Feby. 28, 1915

8. AGE:	Years <u>30</u>	Months <u>8</u>	Days <u>19</u>	If less than one day <u>_____</u> hrs. <u>_____</u> min.
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9. Birthplace Friedens Penn.
(Town, county, and state)10. Usual occupation Nurse11. Industry or business _____12. Name Frank H. Zerfoss13. Birthplace Somerset, Pa.14. Maiden name Bessie E. Robertson15. Birthplace Somerset, Pa.16. Informant Frank H. ZerfossAddress Somerset, Pa. R D 117. Burial _____ Date thereof Nov. 13, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Memorial Park CemeteryLocation Somerset, Pa.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Nov 12 1945 (Date rec'd by registrar) John A. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1945 19 45 at 7- P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 45, to _____ 19 45and that I last saw him _____ alive on _____ 19 45Immediate cause of death _____ DURATIONOpen fracture of skull
(avulsion of skull & brains)Fractured (rt) ribsOther conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations noDate of op. _____Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov/9/45Where did injury occur? Clear Spring Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) US #40 highwayMeans of Injury Thrown out of auto (collision)

DEPUTY MEDICAL EXAM.

23. SIGNATURE H. Robert Wells WASH. CO., MD.Address Hagerstown Md M. D. or otherDate signed Nov. 11/45

RECEIVED

NOV 14 1945

BUREAU N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
City or town Park Hall, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Park Hall, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Andrew Zittle

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife Amanda Zittle

7. Birth date of deceased (mo., day, yr.) July, 25, -1861
6.(c) If alive, give age 84 years

8. AGE: Years Months Days If less than one day
84 4 1 hrs. min.

9. Birthplace Zittletown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Samuel Zittle

13. Birthplace no Record

14. Maiden name no Record

15. Birthplace no Record

16. Informant Floyd Zittle
Address Boonsboro Md. R. 2

17. Burial Date thereof Nov. 29, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Zittletown Cemetery

Location Zittletown Wash. Co. Md.

18. Funeral director Am J Bat & Son

Address Boonsboro Md.

19. Nov. 28 19 45 Wm. Katherine Greenhart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 19 45, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 19 43, to Nov. 26 19 45, and that I last saw him alive on Nov. 17 19 45.

Immediate cause of death Chronic Myocarditis DURATION 2 yrs. 1 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Herbert Wade, M.D. M. D. or other
Address 1 Boonsboro, Md. Date signed 11/28/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11451 10

DEC 3 1945

BUREAU V.A.